

# Dependent Status Change Information Form

## WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201 DE FOREST, WI 53532-2510

TELEPHONE: 608-842- 9102 TOLL FREE: 800-397-3373

WEBSITE: [WWW.WILBENEFITS.COM](http://WWW.WILBENEFITS.COM)



Member's SSN or Member Id: \_\_\_\_\_

Member's Full Name: \_\_\_\_\_

Member Phone Number: \_\_\_\_\_

Member Address: \_\_\_\_\_  
Street State, Zip

Member Email Address: \_\_\_\_\_

Wisconsin Laborers' Health Fund (WLHF) requires immediate notification of individuals who are either new dependents or who are no longer eligible dependents. Failure to promptly notify WLHF may result in the loss of coverage for new dependents and, in the case of former dependents, may result in recovery actions for benefits paid including the loss of right to COBRA continuation coverage. **See Reverse Side of Form for Status Change Codes**

|                                       |               |                       |                          |              |        |               |
|---------------------------------------|---------------|-----------------------|--------------------------|--------------|--------|---------------|
| NAME OF DEPENDENT (LAST-FIRST-MIDDLE) | DATE OF BIRTH | TYPE OF STATUS CHANGE | DATE OF MARRIAGE/DIVORCE | RELATIONSHIP | GENDER | SOC. SEC. NO. |
|---------------------------------------|---------------|-----------------------|--------------------------|--------------|--------|---------------|

DEPENDENT IS ELIGIBLE FOR OTHER GROUP HEALTH PLAN COVERAGE  
IF YES, NAME OF OTHER GROUP HEALTH PLAN

☐ YES ☐ NO

CARD HOLDER NAME & DATE OF BIRTH

EFFECTIVE DATE (MMADD/YY) MEDICAL, DENTAL VISION (Circle all that apply)

|                                        |               |                       |                          |              |        |               |
|----------------------------------------|---------------|-----------------------|--------------------------|--------------|--------|---------------|
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IF YES, NAME OF OTHER GROUP HEALTH PLAN

☐ YES ☐ NO

CARD HOLDER NAME & DATE OF BIRTH

EFFECTIVE DATE (MMADD/YY) MEDICAL, DENTAL VISION (Circle all that apply)

Please complete, sign and return to WLHF including all applicable documents, as described on the reverse side of form, to support the type of status change for each dependent.

By signing this form, I certify that the information provided is complete and accurate as of the date of my signature.

Participant Name (please print) \_\_\_\_\_

Participant Signature \_\_\_\_\_

Date \_\_\_\_\_

**Note: If you would like to make changes to your beneficiaries  
a Beneficiary Change Form will need to be filled out and returned**

## Dependent Status Type and Supporting Documentation Needed

| <b>Code</b> | <b><u>Type of Status Change</u></b>    | <b><u>Required Documentation</u></b>                                                                                                                                                                                                                                                                                                                                                                                               |
|-------------|----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1           | Marriage                               | Marriage Certificate                                                                                                                                                                                                                                                                                                                                                                                                               |
| 2           | Birth / Child (to be added to plan)    | Birth Certificate                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 3           | Adding Stepchildren                    | Birth Certificate and portion of the finalized Judgment of Divorce (when applicable), that includes names of the parties, name of child(ren), who has custody and who has financial responsibility for the child(ren)'s health care expenses. If court documents are not applicable, we will need a notarized letter stating the custodial parent is responsible for all of the child(ren)'s needs along with a brief explanation. |
| 4           | Divorce                                | Finalized Judgment of Divorce – Please only send portions that includes names of the parties, names of children (if any), who has financial responsibility for the child(ren)'s health care expenses, and signature page.                                                                                                                                                                                                          |
| 5           | Name Change                            | A copy of one of the following showing name change: driver's license, social security card, or supporting court documents (when applicable)                                                                                                                                                                                                                                                                                        |
| 6           | Death                                  | Death Certificate                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 7           | New Insurance Coverage for Dependent   | Letter from new insurance showing when coverage started                                                                                                                                                                                                                                                                                                                                                                            |
| 8           | Adoption                               | Order of Adoption or Order Placing Child After Consent                                                                                                                                                                                                                                                                                                                                                                             |
| 9           | Termination of spouse's insurance plan | Termination notification from spouse's group health, dental or vision insurance plan.                                                                                                                                                                                                                                                                                                                                              |
| 10          | Guardianship                           | Judicial decree granting the guardianship.                                                                                                                                                                                                                                                                                                                                                                                         |

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## **Ways to Return Completed Form and Documents**

Please make sure all documents are clear and easy to read

**Mail:**  
WLHF Attn: Eligibility  
4633 Liuna Way  
Deforest, WI 53532

**Fax: (608) 846-3192**  
**Attn: Eligibility – Dep Status Change Form**

**Upload to Website:**

1. Visit [www.wilbenefits.com](http://www.wilbenefits.com)
2. Scroll down to upload to Eligibility
3. Browse your device to upload your saved pdf document

**Email: [Eligibilitywvl@benesys.com](mailto:Eligibilitywvl@benesys.com)**  
**Subject: Dependent Status Change Form**